Wyoming Department of Health Public Health Laboratory 208 S. College Cheyenne, WY 82002 307-777-7431

## REQUISITION FOR INFLUENZA TESTING

## INSTRUCTIONS FOR INFLUENZA TESTING

- > Specimens should be collected within 3 days of symptom onset
- > Specimens should be collected & shipped according to attached protocol
- > Specimens must arrive at the lab within 48 hours of collection
- Maintain Specimen at 2-4 °C and ship on COLD PAK to the WPHL with the completed form

Sentinel	
ID#	
Lab ID#	
Received	
Reported	
Results	
Tech	
1 CCII	

(Please print clearly with black ballpoint pen.)							
Patient Name (Last)	(First)	(MI)	DOB	Gender			
5.0		- DI		/ □ Male			
Patient Address	Ho	me Phone	Age				
		)		□ Female			
Hispanic: ☐ Yes ☐ No ☐ Unk							
Race:   American Indian or Alaska Native   Asian   Black or African American							
☐ Native Hawaiian or Other	Pacific Island	er 🗆 White	□ Othe	er 🗆 Unknown			
Submitting Laboratory Name and Address (return address)				nber			
			( )				
			Fax Numb	er			
			( )				
Attanding Dhysisian Name							
Attending Physician Name COMPLETE ENTIRE SECTIO				C INFORMATION			
COMILETE ENTIRE SECTIO		SAMPLE TYPE	CITESIII	DATE COLLECTED			
Date of onset of illness:/		☐ Nasopharyngeal swab _					
Rapid Flu Test Results:		2 0					
☐ Negative ☐ No rapid test pe	rformed [	☐ Nasal swab		/			
☐ A positive ☐ B positive		☐ Nasal wash/aspir	ate				
☐ A&B positive (Not Differentiated)	[	☐ Other		/			
Was patient hospitalized? ☐ Yes ☐	No ]	Patient Symptoms					
If yes: Hospital		☐ Sore throat	□ Fever (	(≥ 100.0 °F)			
Date Admitted/	[	☐ Headache	□ Nasal	congestion			
Flu Vaccination		☐ Dry cough	□ Shortr	ness of breath			
If yes, date received:/	.   [	☐ Body Aches	□ Diarrl	nea			
Nasal Vaccination ☐ Yes ☐ No		☐ Vomiting	□ Other				

Patient Name:				DOB:			
Highest fever at home° F or □ N/A  Date taken:/			□ <b>N</b> /A	Travel outside USA?			
Highest fever during <u>healthcare</u> visit° F			° F	Date of Travel/			
Did the patient receive antiviral medication?			on?	Does the patient have any of the following?			
□ Yes □ No □ Unknown				□ Asthma			
If yes, complete the table below				☐ Other chronic lung disease			
Drug	Start Date	Number of days	Dosage	□ Cancer			
Tamiflu (Oseltamivir)				<ul><li>□ Neurological disease</li><li>□ Kidney disease</li></ul>			
Relenza (Zanamivir)				☐ Chronic heart /Circulatory disease			
Rimantadine Amantadine				☐ Metabolic disease (including diabetes mellitus)			
Other				☐ Other Chronic Disease			
Does the patient work in a health care facility/setting?  □ Yes □ No □ Unknown				Pregnant?  □ Yes □ No □ Unknown □ Not Applicable			
If yes: Facility				If yes, how many weeks			
Does the patient attend school?				Estimated due date://  Does the patient attend daycare?			
□ Yes □ No □ Unknown				□ Yes □ No □ Unknown			
If yes: School				If yes: Daycare			
Patient's weight kg or lbs				Level (s) of medical care (check all that apply)			
Patient's height cm or ft/in				☐ Clinic visit (outpatient)			
Part of a suspected cluster or outbreak?				☐ Emergency Department/ER visit			
☐ Yes ☐ No ☐ Unknown  If yes, list other possible cases				☐ In-patient admission (hospitalized patient)			
				☐ Intensive Care Unit (ICU)			
				□ Other			
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